| LONDON BOROUGH OF CAMDEN | WARDS:<br>All |
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| **REPORT TITLE**<br>Interim Report of the Screening and Prevention Scrutiny Panel | |
| **REPORT OF**<br>Chair of the Screening and Prevention Scrutiny Panel | |
| **FOR SUBMISSION TO**<br>Health and Adult Social Care Scrutiny Committee | **DATE**<br>27 February 2024 |


**SUMMARY OF REPORT**

This report provides an update on progress of the Screening and Prevention Panel's work to date. The report presents initial findings from interviews and research into cancer screening services. Preliminary recommendations are included, and are grouped into four themes; accessibility and resource, information and marketing, social and cultural, and accountability.

The next steps for the panel are set out at the end of the report.


**Local Government Act 1972 – Access to Information**

No documents that require listing have been used in the preparation of this report.

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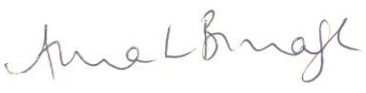
**RECOMMENDATIONS**

That the Committee note and comment on the report.

**Signed:** 

Cllr Anna Burrage, Chair of the Screening and Prevention Scrutiny Panel

**Date:** 14th February 2024

## 1. Purpose of Report

1.1. This report provides an update on progress of the Screening and Prevention Panel's work to date. The report presents initial findings from interviews and research into cancer screening services. Preliminary recommendations are included at section 15, these are grouped into four themes; accessibility and resource, information and marketing, social and cultural, and accountability. The next steps for the panel are set out at the end of the report.

## 2. Introduction

2.1. Even before the pandemic, Camden's coverage of many health screening and prevention initiatives such as cancer screening and (non-Covid) vaccination was typically below the average for London and significantly below the average for the UK.

2.2. Since the pandemic, many health screening and prevention programmes are still not reaching enough target participants. Uptake of some programmes has declined further compared to London and UK averages. Low uptake is driven by societal inequalities and itself contributes to health inequality in the Camden. Improving participation in these programmes is essential in narrowing the gap in life expectancy between the wealthiest and poorest parts of the borough and is critical to the delivery of Camden's Health and Wellbeing Strategy published in 2022, particularly the ambition for everyone to 'live well and age well'.

## 3. Purpose of the Panel

3.1. The objective of this Panel is to conduct an investigation into available screening and prevention programmes to help; a) determine which programmes should be prioritised for attention due to low uptake and demographic relevance, b) create an enhanced understanding of the barriers to take-up and c) facilitate the development of recommendations for how to improve participation across the borough both for where the most major gaps exist but also for where health inequality is worst on the fringes of society.

## 4. Scope

4.1. In the first instance, all adult screening and prevention programmes are considered but scope is narrowed once largest gaps between Camden and London/UK are identified.

4.2. Initial scope includes:

- Cancer screening in Camden
    - Cervical screening
    - Bowel Screening
    - Breast Screening
    - Targeted Lung Health Checks
- Locally delivered screening and prevention programmes
    - NHS Health Checks
    - NHS Diabetes Prevention Programme (NDPP)
- Other national screening programmes
    - Abdominal Aortic Aneurysm (AAA)
    - Diabetic Eye Screening

4.3. This Panel will not scrutinise screening programmes aimed at pregnant women and babies as children do not fall within the remit of this panel's parent committee, Health and Adult Social Care Scrutiny Committee.

## 5. Methodology

5.1. The Panel will review available Camden public health data on existing programmes and past and current participation. Panel members will conduct interviews with relevant organisations such as Public Health officials, Healthwatch Camden, GPs, practice managers, local NHS hospital trusts and patient consultation groups. A literature review will be conducted pertaining to efficacy of UK-wide screening and prevention initiatives to see if learnings can be gleaned from academic studies and organisations such as other local authorities.

5.2. A full literature review will be included in the final version of this panel's report.

## 6. Key lines of enquiry

6.1. Key lines of enquiry will guide interviews and gathering of evidence along three main themes:

- Which programmes in Camden suffer from the lowest relative uptake?
- What are the barriers to up-take of screening and prevention services?
- What approaches to improving uptake (e.g. from other local authorities) have proved most effective and therefore should be prioritised?

## 7. Interviews

7.1. Nature of the interview depends on the individual or type of organisation but will focus on understanding the role that organisation or individual plays in participating in, observing or delivering the screening and prevention programmes. A thorough picture of the types of barriers and where they might feature, plus the incentives which will encourage participation, are required and what, if any, of these issues or characteristics are specific to or unusual for Camden must be explored.

## 8. Findings

8.1. Initial analysis of the data and interviews with Public Health officials shows that Camden lags London and other areas of the country most significantly in the uptake of cancer screening programmes and abdominal aortic aneurysm (AAA) screening. In contrast, Camden reports higher than average uptake of NHS health checks. To ensure the scope of this panel did not become unwieldy, it was decided at an early stage to maintain a focus on cancer screening. This is both because low uptake of cancer screening was already identified as being very problematic for the borough, and also because those programmes cut across many different population demographics and therefore similarities will arise with other non-cancer screening programmes and similar recommendations to improve uptake will apply.

## 9. Cervical screening

9.1. Cervical screening, also called a smear test, is offered to women aged 25-64. It tests for high-risk human papillomavirus (HPV) which is found in 99% of cervical cancers. 25-49 year olds are asked to attend once every 3 years, and 50-64 year olds every 5 years. It is a hidden disease in that its symptoms are undetectable until the cancer is advanced, hence the importance of regular screening.

9.2. Cervical cancer is the cause of death of approximately 850 women per year in the UK but is now almost entirely preventable with the development of the HPV vaccine which, since 2008, has been administered to teenage girls and boys in a school-delivered programme. The World Health Organisation states that it is their ambition to eradicate cervical cancer; to achieve this all countries must reach and maintain an incidence rate of below 4 per 100,000 women and has set targets to be met by 2030 in order to achieve this ambition in the course of this century.

9.3. In the future, the need for a cervical screening programme may be eliminated as incidence of the disease declines (subject to the vaccine uptake holding up). The need for a programme remains as only women below the age of 29 are at present fully vaccinated (and the inclusion of 24-29 year olds is presumably to ensure the vaccination programme continues to have the desired effect).

9.4. Eligibility is determined by GPs who periodically review their patient lists. Invitations go out via a letter from a centralised NHS ‘Cervical Screening Administration Service’ with an information booklet. The GP may also send an invitation via text to the target recipient. Recipients are asked to call their GP surgery to make an appointment. Screening is completed in GP surgeries typically by the practice nurse; a small proportion are also completed in sexual health clinics. Approximately 75% of patients are given a clear result with no need for further follow up and 25% are directed for a follow up colposcopy at a local clinic.

9.5. **Cervical screening invitation process** in detail:

- NHS Digital sends invitations every 3 or 5 years from when last screened depending on the individual's age. Three letters are sent to the individual, inviting them to book an appointment with their GP practice.
- In London, a text message is also sent two weeks after the 1st letter, to remind people that are yet to attend their screen, to do so.
- When NHS Digital generate the list of people to be invited, the list ('prior notification list') is sent to practices to check if there are patients that need to be removed from it.
- As cervical screening is a primary care core service, practices are required via the Quality Outcome Framework (QOF) to follow up non-responders and report on what are effectively self-exemptions (if a patient has been followed up 3 times and not responded) in order for the GP practice to receive payments. The coverage target is 80%. The practice figures will always show higher because of exemption reporting rather than actual % coverage.
- How practices follow up with women who have not responded varies (text, letter, in-person events/talks). Again, there would be variation in activity based on the population the practice serves, sample taker capacity and so on.
- In 2024, the current IT system used for cervical screening will be replaced with the Cervical Screening Management System, designed to help improve management of the whole programme.

9.6. **Cervical screening uptake**:

9.7. For 24-49 year olds, nationally in 2012 74% of eligible women were adequately screened, 68% across London generally and 60% in Camden. By 2022 this had declined to 68%, 59% and 46% respectively. Local analysis indicates uptake is lowest among ethnic minority groups: Chinese (36%), Indian (45%), Other Asian (40%), Pakistani (49%), Other ethnic groups (49%), Other White (53%).

9.8. For 50-64 year olds, nationally in 2012 80% of eligible women were adequately screened, 78% across London and 72% in Camden. By 2022 this declined to 75%, 71% and 63% respectively. Local analysis in Camden indicates uptake is lowest among ethnic minority groups: Irish (61%), Chinese (59%) and Other Asian (62%).

9.9. **Barriers to uptake of cervical screening** emerging from interviews include:

- Awareness: up to 60% of people, and potentially even higher for women in some communities, are not even aware of the existence of screening programmes or that they might qualify for them
- Myths: there is a belief among some communities that 'people like us don't get cancer'; chemotherapy may be damaging for people with black skin; having had only one sexual partner means you can't get it; or the impression is that the test is prohibited according to a religion.
- Privacy: the test is too intimate; concern that the person carrying out the screening may not be female; fear that the test could hurt.
- Decision-making: within some communities especially, it may be that a man is making the decision on behalf of his partner and he does not want her modesty or

privacy invaded; or he assumes that the need for it (or the incidence of cancerous cells if they are found) has arisen because the wife/partner has had relations with another partner.

- Accessibility:
    - Particularly for people with disabilities – transport to the GP surgery, accessing the surgery itself and then climbing on to the examination table are insurmountable for some.
    - Simply finding time to call and make the appointment, availability of GP surgery when calling to make appointment, availability of appointment slots and then finding the time to actually attend the appointment – particularly for carers and women with inflexible employment circumstances or where the appointment is not close to the work location.
    - Some clinics explicitly prohibit children accompanying the participant to the appointment
- Habit: women whose mothers attend cervical screening are more likely to attend screening themselves as it is normalised for them and can become habitual.
- Lack of resources: availability of someone to cover caring responsibilities or the cost of alternative care or even transport to visit the GP.
- Communication: letters or texts may not be in an accessible language; not understanding what it is being offered, or why it's relevant to the recipient.
- Sharing of information: fear of government accessing people's personal data.
- Cost: although screening is free, for certain groups there is the fear that if a cancer is located they won't be eligible on the NHS and will be required to pay for their treatment in a secondary healthcare facility (ie hospital/clinic).
- Appointments in batches: if the 3 or 5 yearly invitation is missed, the next invitation for that cohort may not be for another 3 or 5 years. Routine screening might be losing women as they aren't aware that this will be their only opportunity within that timeframe.

9.10. Initiatives already underway to improve uptake of screening locally and nationally include:

- Implementation of online appointment booking system – the project aims to offer flexible appointment booking options for people across London.
- Cervical cancer prevention training for non-clinical staff – the aim of the project is to build non-clinical staff's knowledge on cervical cancer and screening, to facilitate activities within practices to improve uptake of screening.
- A project of training for health staff in taking samples– the objective of the project is to increase the number of available sample takers across the sector to improve capacity and access.
- YouScreen (HPV self-sampling) project – the study aimed to test the feasibility of incorporating HPV sampling into the cervical screening and assess whether it can increase uptake amongst non-attenders.
- Research is underway into the feasibility and effectiveness of self-testing kits; early data appears to indicate an increase in take-up.

## 10. Bowel screening

10.1. Bowel screening is offered to everyone registered with a GP aged 60-74. Since 2021, the programme has started expanding nationally to include 50-59 year olds and will cover that group within four years. In Camden, the extension to 54 year olds was implemented in 2023. Free testing kits are sent out to eligible recipients every 2 years. Screening comprises a faecal immunochemical test (FIT for short) and uses a diagnostic technique that examines stool samples for traces of non-visible blood, which could potentially indicate conditions including bowel cancer. A small stool sample is taken and posted back to the lab in a pre-paid envelope. Results are returned within two weeks.

10.2. Bowel cancer is the 4th most common cancer in the UK and the second most common cause of cancer death resulting in the demise of approximately 16,000 people per year. Just 10% of bowel cancers are diagnosed via screening and 25% are diagnosed when a patient presents at A&E. NHSE has a target of 75% of cancers being diagnosed at stage 1 or 2; for bowel cancer this is just 40%. Survival rates at stage 1 detection are 90% and just 8% at stage 4. Different regions of the UK have different thresholds for sensitivity of the FIT test and it is thought that this difference may contribute to early levels of detection, potentially leading to health inequalities across the country. Since 2023, GPs have been able to use the home diagnostic FIT test as a first step in diagnosing a patient who presents with symptoms at their surgery rather than having to make a referral to a hospital in the first instance.

10.3. **Bowel screening invitation process** in detail:

- London Bowel Screening Hub sends out the invitation letter to prime individuals (1st letter), then a 2nd letter with FIT kit, followed by a text message reminder for people living in London, and then a 3rd letter reminder letter. After 13 weeks, individual's screening episode (invite window) is closed.
- The GP practice gets notified after that point and that is when it is up to the practices to follow up these non-responders using the standardised code that is automatically entered in the patient's record. Prior to Covid, there might have been a locally commissioned service in place as this is not a core primary care service (unlike cervical screening). As part of the Primary Care Network Contract Directed Enhanced Service (DES), PCNs are required to focus on a screening programme of their choice and focus efforts on lower participating groups to improve uptake. Bowel screening isn't on the list in the current DES.
- There could be some variation in uptake across Camden at this second stage as it is dependent on for example, whether PCNs focus on it and accurate recording by GPs of a patient's current address.

10.4. Nationally in 2015, 57% of eligible adults were adequately screened, 47% across London and 47% in Camden. By 2022 this increased to 70%, 62% and 57% respectively, most of which nationally and locally, came after 2019, but Camden's increase in uptake was substantially lower than elsewhere. Local analysis indicates

uptake is lowest among ethnic minority groups: Pakistani (44%), Bangladeshi (35%), Indians (35%), African (38%) and Other White (45%).

10.5. Themes emerging from about **barriers to uptake of bowel screening** are:

- Communication:
  - the language barrier is a huge issue – up to 60% of Camden's local Chinese, South Asian and African communities are unaware that they are eligible for all sorts of screening, particularly men who are not in the habit of visiting their local doctor;
  - as with other screening programmes, where invited participants have learning disabilities or do not speak/read a reasonable level of English, they may struggle to understand what the test is for when it arrives, the relevance to their lives and/or how to complete the home test and return it.
- Participation of men: men aren't introduced to screening programmes as early as women who have cervical or breast screening from the age of 25 upwards; they are not therefore in the habit of responding in the same way; men also do not tend to reply immediately, they have 'by the way' conversations when they attend the GP for other reasons.
- Accessibility: various physical disabilities, which become more prevalent with age in any case, may make completing and returning the test difficult.
- Aversion: some people are squeamish and find the idea of taking a sample of their own poo very challenging.
- Focus: patient groups rarely discuss screening programmes possibly because they comprise largely of older patients who are not the target (although bowel screening is potentially the most relevant to the older population so could be of more interest).
- Oversight: as it is centralised and not managed locally, it feels impersonal.
- Initiatives already underway to improve uptake of bowel screening locally and nationally include:
  - Bowel screening calling project – to encourage good uptake amongst people being newly invited to the programme as part of the age extension, they are telephoned ahead of a kit being sent to them to provide information about the screening programme and encourage participation.
  - Improving colonoscopy capacity – the project aims to increase capacity to respond to additional demand as the bowel screening age extension programme expands and invites people from 50 years by 2025.
  - Bowel Screening Equity Audit – to understand inequalities in uptake of bowel screening across different population groups.

## 11. Breast screening

11.1. Breast screening is a free NHS test offered to women aged 50 –70 every 3 years. Screening takes the form of a breast x-ray called a mammogram to look for cancer that may be too small to see or feel. The screening service in Camden is provided by The Central and East London Breast Screening Service, with the site located in The Kentish Town Health Centre.

11.2. An automatic invitation will be sent for those aged 50 –70 and registered as female with a GP in the form of a letter inviting the recipient to call a central service or visit the London Breast Screening website to make an appointment. A female mammography practitioner (an expert in taking breast x-rays) will carry out the x-rays. The results are sent to the individual and their GP, usually within 2 weeks. Most women receive a letter to say no cancer was found and that they will be invited again in 3 years time. Some women will receive a letter to say that more tests are needed and they may be referred for a biopsy at a local hospital.

11.3. Breast cancer is the most common cancer in the UK and women are almost 2,000 times more likely to get it than men (and men are not screened for it). Around 11,700 people each year are diagnosed with breast cancer (75 of these will be men).

11.4. Nationally, screening take up is at its lowest level ever and the programme suffers from capacity limitations which made recovery from the pandemic hiatus difficult and reinforces health inequalities. According to a study from the thinktank Demos and the charity Breast Cancer Now, breast cancer is estimated to cost the UK economy approximately £2.7bn annually, which includes over £700m on screening and treatment, and patient productivity loss of £1.8bn relating both to the patient and carers, and the individual costs that people carry, such as out-of-pocket expenses and loss of income. This will continue to rise unless screening uptake improves.

11.5. **Breast screening invitation process** in detail:

- Pre-covid, patients used to be invited by their practice. This meant patients could be invited sometime between when they are 50-53 as opposed to when they turn 50. Now patients are invited according to their NTDD (‘Next test due date’) so it follows the same cycle as bowel and cervical.
- Patients are sent an invitation by the London Breast Screening Hub (managed by Royal Free London) with a date, time and location to attend their screen based on their registered address (the aim is to book a patient in no more than 30 mins from their registered address) 2-4 weeks before their appointment.
- They will then receive reminders of their appointment via text 7 days and 2 days beforehand.
- The patient has the flexibility to contact the hub by phone or go online to change the date, time and location of their appointment if it doesn’t suit them, however, it needs to be at a location managed by the breast screening service for the catchment area.
- If the patient does not attend their appointment, they receive a reminder letter, requesting them to book in when they can; this is sent 5 days after their missed appointment.

11.6. **Breast screening uptake:**

11.7. Nationally in 2012, 77% of eligible women were adequately screened, 69% across London and 61% in Camden. By 2022 this decreased to 65%, 55% and 46%

respectively (although Breast Cancer Now reports that Camden's rate is currently 42%). The national target for take up is 70%. Local analysis of participation by ethnicity is not currently available.

11.8. **Barriers to uptake of breast screening** include:

- Testing procedure: it is perceived to be intrusive, uncomfortable or even painful.
- Accessibility: as for cervical screening, attending a hospital/clinic requires physical mobility – and the mammogram equipment requires physical positioning and manipulation to be positioned correctly.
- Privacy: lack of confidence that it will be a female practitioner, undressing in front of strangers, cultural (or just personal) aversion to intrusion.
- Myths: fear that mammogram causes cancer.
- Time poverty: time required to book and attend a mammogram is greater than booking any other routine screening and problematic for women who are restricted by work or caring responsibilities.
- Limitations: the pandemic hiatus caused a backlog of testing from which the service has not recovered and questions have been raised about the actual appetite for successfully encouraging more women to come forwards if there isn't the capacity to accommodate them in the system.
- Oversight: like bowel, breast screening is not locally managed and the list is generated by the NHS Spine (central NHS database) not local GP so feels impersonal.

11.9. National and local initiatives to improve breast cancer screening take up include:

- Social marketing campaign – a regional campaign to encourage participation in breast screening and raise awareness of its importance.
- Adapting materials for people with a learning disability – develop and send tailored invitation resources to invited individuals to support participation in the programme.
- Raising awareness of gene testing, particularly for BRCA (a faulty gene with links to increased risk of breast cancer) which will encourage enrolment into the programme, particularly for Jewish communities.
- Supporting people with disabilities – the project aims to improve breast screening participation for people with physical and learning disabilities through working with primary care and community learning disability teams to identify adjustments needed for individuals, and put them in place.
- Language support at appointments – the project aims to streamline the language support available at screening sites to improve patient experience and efficiency during the appointments. The project targets people for whom English is not their first language do not or speak low levels of English.
- The breast screening team are planning to recommence sending a second timed appointment letter after a patient misses their first one to help improve uptake.
- The breast screening team are engaging with primary care and spoke at the Camden GP forum in October 2024, and are working on specific projects supporting people with learning disabilities and language support, in addition to attending health promotion events across NCL, to help improve uptake. NCL have also

funded a post in the breast screening team, to follow up and contact non-responders, to book them into an appointment.

## 12. Targeted lung health checks

12.1. Targeted lung health checks (TLHC) are currently being rolled out across the UK and the programme has been in place in Camden since 2022. This programme constitutes a new screening programme to detect lung cancer in anyone who has ever smoked aged 55-74. The national rollout follows a successful opening phase where approximately 70% of the screening took place in mobile units parked in convenient places – such as supermarket car parks – to ensure easy access and focused on more deprived areas where people are 4 times more likely to smoke.

12.2. In Camden, invitation letters are sent out by UCLH based on eligible patients from GP registers. The lung health check comprises of two stages: first a telephone call with a health professional who will carry out a brief assessment of the participant's risk of lung cancer. Secondly, if deemed to be high risk the participant will be invited for a lung health check and low dose chest CT scan. The TLHC service will organise this as required. The sites for attending a lung health check and CT scan appointment are University College Hospital and Finchley Memorial Hospital.

12.3. As a new programme, data on uptake of TLHCs is not currently available.

## 13. Prostate screening

13.1. Prostate screening is not yet available as part of a national programme, however 52,000 men annually are thought to get the disease. Over their lifetimes, 1 in 4 Black men, 1 in 8 White men and 1 in 13 Asian men will develop it. A targeted screening proposal has been submitted to NHS England for Black men over the age of 45 and any men with a history of prostate cancer in the family (presumably if known), and the largest ever screening trial costing £42M has recently been approved to begin recruiting participants from September 2024.

13.2. A 30 second risk-checker has also been developed and published online: https://prostatecanceruk.org/risk-checker.

13.3. Prostate Cancer UK advise that any campaign around prostate cancer needs to highlight three issues:

- Focus on asymptomatic population to catch it early
- Focus on risk awareness in target population
- Exclude practitioner bias for/against PSA test (a blood test which is highly contentious may or may not be a good indicator of the presence of disease; invasive surgery should never be recommended when someone may not have the disease or they may 'die with it, rather than of it').

13.4. GPs, if willing, could initiate regular – perhaps annual – audits without the formal roll out of a screening programme by selection, of ‘at risk’ patients according to:

- Black men aged 45-70
- Men with family history of prostate, ovarian or breast cancer (caused by the same gene)
- Men aged 50-70 in general.

13.5. Those to exclude from this audit would be men who:

- Have had a PSA test in the past 12 months
- Have/have had prostate cancer already
- Are on an end of life pathway.

13.6. However, efficacy of these audits may be conditional upon accurate recording by GPs of ethnicity and family history of patients.

## 14. Why Camden is Different

14.1. What accounts for Camden Borough’s results being lower than those of other London Boroughs, and the rest of the UK? Several factors have been identified as being particularly acute in Camden, which might affect take-up directly or might skew the data; each factor might only adversely influence the data marginally, but taken as a whole, create the significant variation.

1) Camden hosts several universities and therefore has a high and transient student population whose medical data tends to be held “at home”, other than for emergencies.
2) Camden hosts a large population of migrants (of high and low economic status), also transient and with irregular medical data; many foreign nationals are resident in Camden because of ease of access to transport hubs (e.g. St Pancras, Luton, Gatwick airports) who may use health facilities in their home countries, resulting in loss of local data.
3) Camden’s population has a great number of diverse ethnic groups, potentially already marginalised and with poor links into healthcare.
4) The number of homeless people, both on the streets, in hostels or “sofa-surfing” in Camden is substantial, resulting in many residents with inadequate access to medical support.
5) Camden is deemed to have a large wealthy population, which might access private healthcare for screening, resulting in loss of local data.
6) Camden borough also has a significant proportion of young residents, with a level of complacency and sense of invulnerability which militates against take-up of preventative screening.
7) At this stage of this investigation, the issue of number of primary care facilities and GPs per capita compared to other London boroughs and the rest of the UK has not been probed but, if lower, this might also contribute to lower screening rates.

## 15. Preliminary Recommendations

15.1. In conclusion, it is reasonable to concede that achieving national target levels of screening uptake in Camden will not be easy; however, it is therefore is essential that health-related bodies must try even harder to engage and push this as a priority if the borough's population health approach is to be successful.

15.2. A comprehensive approach that addresses cultural, economic, and logistical factors is crucial for the success of any and all cancer screening programmes. Further to this investigative work, recommendations for improvement of screening are captured under four main headings, and learnings can be extended to other screening and prevention programmes.

15.3. These recommendations are, as yet, unrefined and – where they aren't yet – need to be focused on specific individuals or organisations. This will happen as a follow up to the next phase of this panel's investigation.

15.4. **Accessibility and resources**

15.5. Fundamentally, the screening offering needs to be designed around the needs of the population rather than constrained by the apparent unquestioned inherent limitations of the service:

- Make booking as easy as possible: offer online, phone and in-person booking.
- Offer a wider variety of time slots including evening and weekends.
- Ask GPs to offer reciprocal clinics to the extend the range of locations available for cervical screening.
- Ensure clinics, treatment rooms and furniture are disabled-accessible or adaptable.
- Deploy the vaccine bus as a mobile clinic for cervical screening (at a minimum) and publicise location in advance via community groups, local and social media – and ask the community themselves when deciding where to visit.
- Dispense bowel testing kits (and blood pressure testing kits) via the Camden mobile health bus.
- Dispatch public health officers to hand deliver and collect bowel testing kits for patients with recorded disabilities.
- Offer money or vouchers for attendance to carers or those on income support – work with Camden Carers to determine a reasonable rate for compensation and tap into their care network to offer trustable replacement care.
- Run cervical screening or mammography clinics which overtly accommodate care recipients, e.g. children/grandchildren, while the participant is undergoing testing.
- Pioneer by creating a women's health hub in Camden where staff are guaranteed to be female, offer a range of health services including community gynaecology and *ad hoc* testing on a scheduled or drop-in basis for those women who have missed their 'every X years' slot.
- Prepare now for the introduction of self-testing for HPV cervical screening with urine testing as soon as it is available (likely 2025) – alternatively ask the University of Manchester to expedite their study or include Camden in their research phase.

- Public health to write to private GPs in the area requiring them to ask patients for permission to return the results of private cancer screening to the NHS Spine.
- Ultimately, the healthcare system needs to be sufficiently flexible to enable the 'by the way' conversations to allow GPs or hospital clinicians to direct patients to have tests when they are off-cycle for screening.

15.6. **Information and marketing**

15.7. The screening journey is not recognised or well-understood by many people. Pertinent and transparent information is not getting through to every group that needs it regarding the availability of screening and the relevance of that screening to the individuals that should be participating.

- Review and rewrite all letters and accompanying information to ensure they are in basic English and other community languages.
- Make the case in simple language at every opportunity (letters, texts, marketing materials) about the preventative benefits of screening.
- Personalise the offer within the context of the screening offered.
    - E.g. "X % of Black women aged 50-55 will develop breast cancer"
    - Not "Contact your GP to book", but "We have booked you an appointment at X time at Y location – please call/go online to select an alternative".
- Ensure all communications state, in effect, says "Do it now, this is your only chance for X years!" (unless an alternative, more flexible system can be created).
- Texting patients is useful but not sufficient – context and relevance to the target recipient is essential, ideally in their preferred language.
- Create an online portal for everyone to access their own records or schedule so they can see when they are due to do have their next screening.
- Improve the NHS app to include a section on screening.
- Introduce the concept of taking personal responsibility for screening participation alongside other beneficial health-related habits in schools, e.g. when students are given their HPV vaccine at age 14, include a lesson on health screening and what to expect in the future, and present them with a leaflet and timeline to take home that may have the benefit of reaching their family too – and use the children to spread the message.
- Public health to work with Camden GPs to (i) determine the proportion of ethnicities represented in their patient population and (ii) ensure they know the relative prevalence of cervical/bowel/ breast/prostate within those communities, e.g. high prevalence of breast cancer among Black women which might warrant more personalised engagement to encourage them to attend their mammogram appointment.
- Ensure ethnicity is linked to screening data for purposes of potential risk assessment and clarity of communication.

15.8. **Social and cultural**

15.9. Deeper exploration and penetration into the myths around screening and cancer itself, and the disconnect between the reality and perception, are critical to

improving uptake. The issue of screening uptake via other means is also a cultural problem because where people prefer to use other routes it would be helpful to capture that and even explore their rationale.

- The language barrier is a common thread across all screening programmes; up to 60% of members of ethnic community groups investigated by Camden Healthwatch reported that they were unaware that screening existed or that they were eligible for it.
- Examples exist of NHS staff, e.g. practice nurses, working with voluntary and community groups to engage and educate them in the importance of screening practitioner engagement needs to be extended into a range of communities who are particularly under-represented in the uptake figures – *more interviews needed here to understand how to link up healthcare providers with community groups.*
- Engage with private GPs to ask them to share their patients' screening test results into the NHS, or give them a pro forma letter to give to their patients for them to submit the results themselves to NHSE/Spine.
- Provide NHS GPs with a pro forma letter to send to registered patients who they believe may be accessing private healthcare or healthcare in a home country with a simple return slip/QR code to respond indicating they have been tested and where possible the outcome.
- Make strong, well-publicised commitments stating that cervical and breast screening are conducted by female practitioners and auxiliary functions within clinics are staffed by females to help avoid speculation or concern.

15.10. **Accountability**

15.11. It is often unclear who is responsible for ensuring good screening uptake and ultimately accountable for the success of the offerings; GPs are financially incentivised for take up of cervical screening on a practice level but no single organisation or individual holds responsibility for Camden. Different pathways for each screening programme and the perception that most are 'national' or NHSE initiatives make local accountability problematic.

- A stated objective of the NCL Cancer Alliance is to 'Meet national screening uptake targets'; the CEO of NCL Cancer Alliance should, therefore, be required to report annually to Camden's Health and Adult Social Care Scrutiny Committee or the borough's Health and Wellbeing Board specifically on this borough's screening uptake.
- NCL Alliance should also do a very focussed study on which demographic groups do/do not attend screening in Camden and share the results with GPs and the Council.
- GPs within the borough should be required to publish and publicise their screening rates both in their surgeries and online to highlight to patients the surgeries' performance and make patients aware of their need to contribute by partaking thus engendering competition and accountability.

- Every GP practice should have one named person who can speak to patients about screening programmes and answer questions about their eligibility or what happens after testing.
- Success such as an improvement in uptake by GP practice or in overall rates across the borough should be celebrated and publicised within specific communities, in the local press and on social media.
- As is the case already for cervical screening, GPs could be incentivised to do periodic checks of other screening programmes and be compensated for the time invested in doing so.
- Raising the screening issue as a regular item on the agenda of patient representative groups at GP practices and local hospitals would also help focus healthcare practitioners on their local outcome.

## 16. Next steps for the Screening and Prevention Panel

16.1. In the next phase of work, this panel will conduct another round of interviews with patient groups, health practitioners and health officials to test initial findings and finesse recommendations. The panel will also involve a variety of community groups and council officers who interface with them most frequently to determine how best to engage them in the process of screening uptake improvement.

16.2. Further research will also be conducted to establish why Camden fares better with uptake of NHS health checks than it does with other screening and prevention programmes as this could lead to valuable and easily applicable learnings.

16.3. The panel will also explore further the implications of low screening through a more focussed health inequality lens, by considering the specific needs of the physically disabled, learning disabled, carers, the homeless, the mentally ill, refugees/migrants and people who aren't eligible for NHS treatment and may have to pay for treatment should they be diagnosed via free routine screening.

16.4. The literature will be finalised and more examples of best practice will be investigated to add weight to recommendations.

16.5. Finally, but not least, the panel will explicitly link findings and recommendations to Camden's Health and Wellbeing Strategy.

## 17. Finance Comments of the Executive Director Corporate Services

17.1. The Executive Director of Corporate Services has been consulted on the contents of the report and has no comments to add to the report.

## 18. Legal Comments of the Borough Solicitor

18.1. The Borough Solicitor has been consulted on the contents of the report and has no comments to add to the report.

## 19. Environmental Implications

19.1. No environmental implications have been identified.

**REPORT ENDS**